STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243

CERTIFIED PEER SUPPORT SPECIALIST
INACTIVE STATUS REQUEST

A Certified Peer Support Specialist who is in good standing with the Office of Consumer Affairs and his or her employer may request inactive status if he or she is unable to meet the requirements of certification due to an unforeseen circumstance.

Inactive status will not be granted for failure to comply with the On-Going Education Guidelines of certification or reported violations of the Certified Peer Support Specialist Code of Ethics.

- Do not alter the form from its original format.
- Write legibly in only black or blue ink.
- Do not use nicknames or abbreviated forms of your legal name.

1) Name *(please print):* _____

Certification Number: _____ Certification Date: _____

Social Security Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: (____) _____ - _____ Email: _____

2) Are you currently employed by an agency that is licensed by the Tennessee Department of Mental Health and Developmental Disabilities, and under the general supervision of a mental health professional?

Yes _____ No _____

If yes, please provide the following employment information:

Employer: _____

City: _____ State: _____ ZIP: _____

Supervisor's Name: _____

Telephone Number: (_____) _____ - _____

3) Please briefly describe the extenuating circumstance(s) that renders you unable to meet the required competencies and/or scope of activities requirements of certification:

_____

_____

_____

_____

My signature below affirms that all of the information contained in this verification form is true and correct to the best of my knowledge. I understand while on inactive status, I will not present myself as a Certified Peer Support Specialist, and nor will I engage in or perform any activity for which a Peer Support Specialist certification is required.

I understand that knowingly providing false information shall be grounds to terminate my certification.

_____ _____

Signature of Applicant Date

Do Not Write Below This Line

_____

Internal TDMHDD – OCA Use Only

Date received: _____

Date reviewed: _____ Approved _____ Not-approved _____

Date letter of findings mailed to applicant: _____

If approved, date inactive status letter mailed to agency: _____

Date information recorded in data-base: _____

Notes:

Processed by: _____